FOR ~~STATE~~ HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM5. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06184

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06180

1. DECEASED-NAME (Type or Print): First BERNARD Middle CASMIR Last BARANOWSKI

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ Month APRIL Day 6 Year 1969

2b. HOUR 9:10 AM

2c. DATE PRONOUNCED DEAD Month APRIL Day 6 Year 1969

2d. HOUR 9:10 AM

3. SEX M

4. RACE W

5. DATE OF BIRTH APR 23 1924

6. AGE (In years last birthday) 44 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (State or Foreign country) BALTIMORE

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH WORCESTER Md.

10. CITY OR TOWN OF DEATH Ocean City, Md

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital - give street address) 309 Baltimore Drive

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Police Officer

12b. KIND OF BUSINESS OR INDUSTRY Police

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md

13b. COUNTY —

13c. CITY OR TOWN BALTIMORE

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET AND NUMBER 3507 JUNEWAY

14. FATHER'S NAME First FRANK Middle Last BARANOWSKI

15. MOTHER'S MAIDEN NAME First MARY Middle Last HARLA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II

16b. SOCIAL SECURITY NO. 212-20-0411

17. INFORMANT MRS ANNA BARANOWSKI ADDRESS 3507 Juneway Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY Occlusion Acute — 2 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD with coronary sclerosis — ?

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) F. J. TOWNSEND JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ADDRESS (Street, city, town, or county) Ocean City Md.

22b. DATE SIGNED Apr 6, 1969.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 4/10/69

23c. NAME OF CEMETERY OR CREMATORY Baltimore, National

23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc, Baltimore, Maryland

25a. REC'D BY REGISTRAR DATE APR 8 1969

25b. REGISTRAR'S SIGNATURE [signature]

VR A15ME (5) 10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06185 **CERTIFICATE OF DEATH** 06181

1. PLACE OF DEATH
a. COUNTY: Worcester - Whaleysville MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleysville, Maryland
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleysville, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Josephine; Middle:; Last: Bunting
4. DATE OF DEATH: Month: April; Day: 30; Year: 1969
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 12, 1884
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months ~~10~~; Days ~~18~~; IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland Worcester-Whaleysville
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lybrand Hudson
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Mumford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 222-22-8461-A
17. INFORMANT: Catherine Hall, Whaleysville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
4310
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) myocarditis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1/67, 19___, to 4-30, 1969 that (I) (we) last saw the deceased alive on 4/26 1969, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Clifford E. Schott M.D.
22d. ADDRESS: Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
23b. DATE THEREOF: May 3, 1969
23c. NAME OF CEMETERY OR CREMATORY: Red Men's
23d. LOCATION (City, town or county) (State): Selbyville Delaware

24. FUNERAL DIRECTOR: Richard T. Watson ADDRESS: Selbyville, Del.
25a. REC'D BY REGISTRAR DATE: MAY 5 1969
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
20M 1/65

1

06186

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06182

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First ARVILLE Middle JAMES Last DUNCAN

2a. DATE OF DEATH: Month April Day 5 Year 1969

2b. HOUR: 12:05 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Jan. 13, 1900

6. AGE (In years last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Pocomoke City

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 209 Sixth Street

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Dealer

12b. KIND OF BUSINESS OR INDUSTRY: Automobile

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Worcester

13c. CITY OR TOWN: Pocomoke

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 209 Sixth Street

14. FATHER'S NAME First William Middle B. Last Duncan

15. MOTHER'S MAIDEN NAME First Florence Middle Olivia Last Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service): --

16b. SOCIAL SECURITY NO.: 215-26-5379

17. INFORMANT: Mrs Ethel L. Duncan, Address: Pocomoke, Md.

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Cancer.

1538

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon. — 2 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

none

19a. DATE OF OPERATION: April 1967

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Colon.

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 1967, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on ~~1969~~ April 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Joseph C. Fitzgerald

DEGREE: ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: April 5, 1969

22d. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald, M.D.

22e. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4-7-1969

23c. NAME OF CEMETERY OR CREMATORY: First Baptist

23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md.

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: APR 10 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

VR A15 (a) 30M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06187

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06183

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: Box 87
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Calvin — Middle: Ernest — Last: Fisher
4. DATE OF DEATH: Month: 4 — Day: 7 — Year: 1969
5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7-23-64
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Berlin
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Eddie Holland
14. MOTHER'S MAIDEN NAME: Annabel Fisher
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annabel Fisher — Address: Box 87, Newark Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe head trauma and hemorrhage
DUE TO (b) Avulsion of soft tissues from neck
DUE TO (c) chest and both hands
814.7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 30 seconds

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by truck on Market street in Snow Hill
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m.: April 7 1969 — 12 noon
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street
20f. (City or town) (County) (State): Snow Hill, Worcester Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Lloyd O. Long M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): Lloyd O. Long, M. D., 104 Bay Street, Snow Hill, Maryland Worcester Co.
22. DATE SIGNED: April 10 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-10-69
23c. NAME OF CEMETERY OR CREMATORY: Williams A.M.E.
23d. LOCATION (City or Town) (County) (State): Newark Worc. Md.
24. FUNERAL DIRECTOR: Loretta B. Jolley — ADDRESS: Jersey Rd. Rt. 2 Salisbury Md.
25a. REC'D BY REGISTRAR: DATE APR 14 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

7 1

**FOR STATE HEALTH DEPT.**

06188

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06184

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: WALTER | Middle: ERIC | Last: GOERING | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month 4 Day 17 Year 1969 — 2b. HOUR AM PM 6:10 |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 10-5-1904 | 6. AGE (In years last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 2c. DATE PRONOUNCED DEAD Month 4 Day 17 Year 1969 | 2d. HOUR AM PM 8:30 | | |
| 7a. BIRTHPLACE (State or foreign country): Germany | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: WORCESTER Md. |
| 10. CITY OR TOWN OF DEATH: Pocomoke City | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt. 13 - Holiday Inn | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Civil Engineer | 12b. KIND OF BUSINESS OR INDUSTRY: Building |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Wisconsin | 13b. COUNTY: Milwaukee | 13c. CITY OR TOWN: Milwaukee | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 2851 N. 78th Street |
| 14. FATHER'S NAME First: Henry | Middle: -- | Last: Goering | 15. MOTHER'S MAIDEN NAME First: -unk- Middle: Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes | (If yes give war or dates of service): WW 2 | 16b. SOCIAL SECURITY NO.: - unk - | 17. INFORMANT ADDRESS: Mrs Walter Goering, Milwaukee, Wis. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial Infarction | 3 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic Heart Disease | 3 or 4 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Lloyd O. Long M.D.

EXAMINER'S NAME (Type): Lloyd O. Long, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

22b. DATE SIGNED: April 17, 1969

ADDRESS (Street, city, town, or county): Snow Hill, Md.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Removal | 23b. DATE: 4-18-1969 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Wisconsin Memorial | 23d. LOCATION (City or Town) (County) (State): Brookfield, Wisconsin |
| 24. FUNERAL DIRECTOR: Robert H. Watson | ADDRESS: Pocomoke City, Md. | 25a. REC'D BY REGISTRAR DATE APR 21 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge |

Robert H. Watson

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

06189

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07691

Item#2a, FilmGL12 5/1

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE HEALTH DEPT.**

1. DECEASED-NAME (Type or Print): First Edward Middle V. Last Holland

2a. DATE KNOWN OF DEATH / EST-MATED: Month April Day 30 Year 1969

2b. HOUR: M

3. SEX: Male

4. RACE: Negro

5. DATE OF BIRTH: Mar. 31, 1890

6. AGE (In years last birthday): 79 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

2c. DATE PRONOUNCED DEAD: Month May Day 1 Year 1969

2d. HOUR: M

7a. BIRTHPLACE (State or foreign country): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Snow Hill

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rural - Snow Hill

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.

13b. COUNTY: Worcester

13c. CITY OR TOWN: Snow Hill

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: R.F.D. I Bx. 182

14. FATHER'S NAME: First Irving Middle Holland Last

15. MOTHER'S MAIDEN NAME: First Mary Middle Last ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO: None

17. INFORMANT: Lola Hudson ADDRESS: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA — HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b) CHRONIC MYOCARDIAL INSUFFICIENCY — 2 YRS

DUE TO, OR AS A CONSEQUENCE OF

(c) ARTERIO SCLEROTIC HEART DISEASE — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert C. Lamar M.D.

EXAMINER'S NAME (Type): ROBERT C. LAMAR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: MAY 4, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5-5-69

23c. NAME OF CEMETERY OR CREMATORY: Home Beneficial Cem.

23d. LOCATION (City or Town) (County) (State): Stockton Wor Md.

24. FUNERAL DIRECTOR: Daniel Lee

ADDRESS: New Church, Va.

25a. RECD BY REGISTRAR: MAY 7 1969

25b. REGISTRAR'S SIGNATURE: Mildred Judge

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1 68

1

06190

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06185

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: Jerry Middle: Last: Palmer

2a. DATE OF DEATH Month: Apr. Day: 4 Year: 1969

2b. HOUR M

3. SEX: Male

4. RACE: Negro

5. DATE OF BIRTH: Apr. 14, 1880

6. AGE (in years last birthday): 88 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (State or foreign country): Tenn.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Pocomoke

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 705 S. - 4th St.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md.

13b. COUNTY: Worcester

13c. CITY OR TOWN: Pocomoke

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 705 S. - 4th St.

14. FATHER'S NAME First: Unknown Middle: Last:

15. MOTHER'S MAIDEN NAME First: Unknown Middle: Last:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Edith Palmer Address: 705 S. 4th St. Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease — 7 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

1. Hypertension 2. Generalized Arteriosclerosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from May 16, 1966, to Apr. 4, 1969, that (I) (~~we~~) last saw the deceased alive on Apr. 4, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Charles W. Trader, M.D. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 4-7-69

22d. PHYSICIAN'S NAME (Type): Charles W. Trader, M.D.

22e. ADDRESS: 302 Market St., Pocomoke, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4-9-69

23c. NAME OF CEMETERY OR CREMATORY: Hall's Hill Cem.

23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.

24. FUNERAL DIRECTOR: Samuel Lawson

ADDRESS: New Church, Va.

25a. RECD BY REGISTRAR DATE: APR 11 1969

25b. REGISTRAR'S SIGNATURE:

VR A15 (4) 30M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06191

# CERTIFICATE OF DEATH

06186

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Berlin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: Eva Belle Pennewell
4. DATE OF DEATH: Month: Apr. Day: 16 Year: 1969
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 5 1879
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Berlin Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Gray
14. MOTHER'S MAIDEN NAME: Sallie Carey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Jay McCrosson — Address: Laurel Springs N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocarditis.
DUE TO (b): Chronic Myocarditis.
DUE TO (c): Cerebra vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2-15-, 1969 to 4-16-, 1969, that (I) (we) last saw the deceased alive on 4-14 1969, and that death occurred at 12 P.M. from causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Clifford E. Schott MD
22d. ADDRESS: Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/19/69
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Evergreen
23d. LOCATION (City or Town) (County) (State): Berlin Wor Md

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE: APR 21 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

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06192

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06187

1. DECEASED-NAME (Type or print): First: Jane | Middle: Pearl | Last: Sherman
2a. DATE OF DEATH: Month: April | Day: 12 | Year: 1969
2b. HOUR: 5 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: June 14, 1889
6. AGE (In years last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Pa.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Snow Hill
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 106 Powell St.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Snow Hill
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 106 Powell St.
14. FATHER'S NAME First: William | Middle: | Last: Brown
15. MOTHER'S MAIDEN NAME First: Sara | Middle: | Last: Clark
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----
16b. SOCIAL SECURITY NO.: 214267315D
17. INFORMANT: Mrs. Carol E. Snyder, Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cachexia & Anemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: month
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial & Renal Deficiency — year
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. | City or Town | County | State

22a. I certify that (I) (~~this hospital~~) attended the deceased from June, 1966, to Apr. 12, 1969, that (I) (~~we~~) last saw ~~the deceased~~ alive on Apr 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Robert C. La Mar M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 4/14/69
22d. PHYSICIAN'S NAME (Type): ROBERT C. LA MAR M.D.
22e. ADDRESS: 104 Bay St Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/15/69
23c. NAME OF CEMETERY OR CREMATORY: Spence Baptist
23d. LOCATION (City or Town) (County) (State): Snow Hill, Md.
24. FUNERAL DIRECTOR: Gerald C. Bounds — ADDRESS: Snow Hill Md.
25a. REC'D BY REGISTRAR DATE: APR 16 1969
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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06193

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06188

1. DECEASED-NAME (Type or print) First: Hazel Middle: Last: Simpson
2a. DATE OF DEATH Month Day Year: Apr. 3 1969
2b. HOUR: M
3. SEX: Female
4. RACE: Negro
5. DATE OF BIRTH: May 8, 1928
6. AGE (In years last birthday): 40 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Pocomoke
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 426 Oxford St.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Cook
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 426 Oxford St.
14. FATHER'S NAME First: Randolph Middle: Fisher Sr. Last:
15. MOTHER'S MAIDEN NAME First: Naomi Middle: Williams Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 218-20-9035
17. INFORMANT: Randolph Fisher Sr. Address: Tampa, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c): Rheumatic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 11/69, 19____, to death, 19____, that (I) (~~we~~) last saw the deceased alive on 4/1/69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 4/7/69
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-9-69
23c. NAME OF CEMETERY OR CREMATORY: Hall's Hill Cem.
23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.
24. FUNERAL DIRECTOR: [signature] ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR DATE: APR 11 1969
25b. REGISTRAR'S SIGNATURE: [signature]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06194

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06189

1. DECEASED-NAME (Type or Print): First ANNA Middle Gertrude Last Weber URY

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Apr Day 20 Year 1969 — 2b. HOUR 8A M

2c. DATE PRONOUNCED DEAD Month April Day 20 Year 1969 — 2d. HOUR 9A M

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: Sept 24 1903 — 6. AGE (in years last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (State or foreign country): New Jersey — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] — 9. COUNTY OF DEATH: Worcester Md.

10. CITY OR TOWN OF DEATH: Ocean City — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Bay Shore Drive — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Post Office Dept — 12b. KIND OF BUSINESS OR INDUSTRY: US Govt.

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: VA — 13b. COUNTY: Arlington — 13c. CITY OR TOWN: Arlington — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 3424 S. Utah St Arlington VA.

14. FATHER'S NAME: First Fred Middle L. Last Weber — 15. MOTHER'S MAIDEN NAME: First Margaret Middle Hebar Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service) — 16b. SOCIAL SECURITY NO.: 102-20-232 — 17. INFORMANT: Mrs Dorothy Shelton, daughter, — ADDRESS: Arlington, VA.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD + RHD with Hypertension — 5 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE F. S. Townsend Jr. M.D.

EXAMINER'S NAME (Type) F. S. Townsend, Jr. — CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county) Md 21842

22b. DATE SIGNED Apr 20, 69.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 4/24/69 — 23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Cemetery — 23d. LOCATION (City or Town) (County) (State): Hakensack, N. J.

24. FUNERAL DIRECTOR: Everly-Wheatley Funeral Home — ADDRESS: Alexandria, Virginia — J. S. Everly

25a. REC'D BY REGISTRAR DATE APR 24 1969 — 25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15ME (5) 10M REV. 1/68